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Variables in Health Care Policy Making: Resolving A Quandary

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Contemporary debate on health care resource management is tied to a central moral issue: how to achieve an optimum level of reasonable or appropriate treatment based on the medical condition of each patient. Failure to tackle and resolve this issue in a confident and forthright manner ensures that the present approach to health care decision-making will continue in a state of indecisiveness if not, indeed, lethargy. Undergirding this moral issue is the foundational economic dilemma of controlling costs while limiting access to health care resources. Crafting a just solution to an equitable distribution of finite health care resources is, indeed, a quandary, if not almost an impossibility. What this article seeks to do, nonetheless, is to undertake an examination of the principles, socio-economic values and public policies needed to formulate health care compromises necessary to achieve greater stability in the normative decision-making process. In turn, this will ensure, ideally, a level of distributive justice in the total allocative process.

DISTRIBUTIVE JUSTICE AND THE JUST SOCIETY

Distributive justice, as a theory, can be traced back historically at least two millennia. Both Aristotle and Plato addressed the question of how a society or group should allocate its scarce resources among those with competing claims or needs, and the Talmud addresses how creditors can make claims on the estate of a deceased creditor.[1] Considered to be but one element in the classic division of justice by Aristotle,[2] the theory of distributive justice was passed down by Aquinas to the Christian tradition.[3] Aristotle and Plato saw justice as neither an instrumental nor a procedural mechanism for achieving fairness or, for that matter, the fulfilment of any type of social contract. Instead, they embraced the classical notion of it as a value – a principle of moral conduct between and among those within human societies.[4]

For most contemporary thinkers, distributive justice attempts to supply to individuals or groups their due proportion of goods, services or opportunities.[5] In this regard, justice is seen as calculating this, because it measures what is to be given or withheld.[6] "Operational justice" is viewed, then, as entailing the exercise of power as the central mechanism "for giving or taking away according to proportional deserts".[7] In a just society, justice requires fair equality of opportunity and is thus equated

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[1] Roemer JE, *Theories of Distributive Justice* (Harvard University Press, Cambridge, Mass, 1996) p 1.

[2] Aristotle, *Nicomachean Ethics* v 4. 1131b25–1132b20 (Bywater J, ed) (Clarendon Press, Cambridge, 1894).

[3] Miller D, *Principles of Social Justice* (Harvard University Press, Cambridge, 1999) p 2.

[4] Pellegrino ED, "Rationing Health Care: Inherent Conflicts Within the Concept of Justice" in Bondeson WR and Jones JW (eds), *The Ethics of Managed Care: Professional Integrity and Patient Rights* (Kluwer, New York, 2002) pp 1-2.

[5] Finnin WM and Smith GA, *The Morality of Scarcity* (University of California Press, Berkeley, 1979) p 79.

[6] Finnin and Smith, n 5, p 79.

[7] Finnin and Smith, n 5, p 79.

with fairness.[8] Consequently, society should be required to guarantee for its members a fair share of what is required for them to pursue their individual ends.[9]

In order to ensure an equality of opportunity for all is not unduly burdensome, a principle of just sharing designed to equalise financial costs to illness is necessary. Such a principle would seek to recognise that all financial burdens associated with medical misfortune should be shared equally by both the healthy and the unhealthy alike unless, that is, individuals can "control those misfortunes by their own choice".[10] In today's practical world, however, noble though this sentiment may be, the sick have neither financial nor moral claim on their fellow citizens and this will, no doubt, continue to be the situation for the foreseeable future.[11]

CHALLENGING THE NEW MEDICINE

New medical technologies tied to gene therapy and stem cell research are designed not only to maintain and extend qualitative existence but to reshape the limits of mortality.[12] Efforts to apply justice to the new medicine through genetic control, which have the effect of shaping the limits and/or quality of the human gene pool, are bound to be met with opposition, especially from those who would view such efforts as violating a more fundamental and profound ethical ideal: that of respect for all human life. Within this ideal are to be found such ambiguous terms as "sanctity", "dignity of human life" and "reverence for human life",[13] all of which, as abstract principles, lack the specificity of a rule but nonetheless have the social power to be taken as either unyielding a priori standards of conduct or, in fact, rules for which no exceptions are tolerated.[14]

Love is seen as the driving force behind any true vision of a just society which, in turn, validates the dignity of the human person. Indeed, the inner fullness of justice is only attained in love.[15] Since all laws are set with a hierarchy whose foundation is, according to Augustine, to be found in love, the ethics of love is viewed properly as the very essence of justice.[16] In the end, if a spirit of love, humaneness or compassion guides the shape and direction of the new medicine, its response will be a reasonable and proper one – one directed toward minimising human suffering and maximising the social good which, in turn, allows attainments of the "good life".[17]

RATIONING AS A NORMATIVE STANDARD

Although lacking a clear and unambiguous definition, rationing may nonetheless be seen as a process whereby some are, temporarily and against their wishes, left without types of health care that would otherwise provide a benefit to them.[18] In addition to referring to these general limitations, rationing

[8] Gostin L, *Public Health Law and Ethics* (University of California Press, Berkeley, 2002) pp 90, 91.

[9] Daniels N, "Justice, Health, and Health Care" in Rhodes R, Battin MP and Silvers A (eds), *Medicine and Social Justice* (Oxford University Press, Oxford, 2002) pp 6, 8; Menzel P, "Justice and the Basic Structure of Health Care Systems" in Rhodes, Battin and Silvers, n 9, Ch 2.

[10] Menzel, n 9, p 34.

[11] Daniels, n 9, p 16.

[12] Smith GP, "Setting Limits: Medical Technology and the Law" (2001) 23 Syd LR 283; Annas GJ, "The Man on the Moon, Immortality, and Other Millennial Myths: The Prospects and Perils of Human Engineering" (2001) 49 Emory LJ 753; Kirby MD, "Bioethical Decisions and Opportunity Costs" (1986) 2 J Contemp Health L and Pol'y 7.

[13] Smith GP, "Quality of Life, Sanctity of Creation: Palliative or Apotheosis?" (1984) 63 Neb LR 709.

[14] De Nicola D, "Genetics, Justice and Respect for Human Life" (1976) 11 *Zygon* 115 at 124-125.

[15] Referencing the Synod of [Roman Catholic] Bishops, "Justice in the World" reprinted in O'Brien DJ and Shannon TA (eds), *Catholic Social Thought: The Documentary History* (Orbis, Maryknoll, NY, 1998) p 293; Fletcher J, "Love is the Only Measure" (1966) 83 *Commonweal* 427.

[16] Hall J, "Religion, Law, and Ethics – A Call for Dialogue" (1978) 29 Hastings LJ 1257 at 1267.

[17] Smith GP, *The Christian Religion and Biotechnology: A Search for Principled Decision-making* (Springer, New York, 2005); Smith GP, "Policy Making and the New Medicine: Managing a Magnificent Obsession" (2008) 3 J Health L & Pol'y 303.

[18] Kilner J, "Allocation of Health Care Resources" in *Encyclopedia of Bioethics* (rev ed, Macmillan, New York, 1995) Vol 2, p 1067.

may encompass, as well, very "specific treatment decisions for particular patients" at the bedside.[19] Alternatively, rationing is seen as a means of providing every citizen with a guaranteed level of basic health care – this, by excluding from coverage those treatments considered to be "outside" the package.[20] One point in this analysis is certain: rationing is the central health care policy issue of the day.[21] Long viewed as haphazard and unprincipled, rationing occurs today as it always has.[22] Yet the term is softened considerably by referring to it as merely allocations of health care resources[23] tied, inescapably, to a foundation in risk-benefit analysis.[24]

Among the approaches to rationing used widely are:

- a "first come, first served" system of queues;
- random selection (which takes no account of the gravity of either the patient's conditions or of the medical benefit);
- ability to pay;
- triage systems based on medical urgency; and
- more recently, systems tied to computations of quality adjusted life years (QALYs) which are designed to test the appropriateness of treatment.[25] It has been suggested that treatment considered to be unsafe, unkind, unsuccessful or unwise is inappropriate and should be withheld.[26]

THE ETHICS OF RATIONING

Lamm, in suggesting a working ethical principle for distributing health care resources for the elderly, created quite a furore among the elderly when he urged that health care resources be distributed along a utilitarian principle so as to maximise the long-run general happiness of the entire community and not only the debilitated, chronically ill, or very elderly as individual members of it.[27] In other words, he argued that the greatest health resources should go to the greatest number of individuals capable of using them effectively. The reality of this harsh statement meant that, in Lamm's view, the elderly have "a moral duty to forgo further health care and to accept their death".[28] Children, he maintained, have more opportunities to flourish and achieve happiness; therefore, it was only logical that they should deserve a greater share of health resources than the elderly. This once again raises the issue of intergenerational equity or justice.

A society surely cannot consider itself a noble one if it does not respect the individuality of its members, even when to do so creates the appearance of running counter to the general happiness of the community at large. Any society runs the risk of dividing itself if it seeks to withhold health care from the elderly based on the argument that the "return" on such an investment can never be realised economically because of the limited lifespan of the recipient. The Lamm thesis challenges society to reallocate its health care resources in a way that does not abandon the elderly yet achieves a balance

[19] Kilner, n 18, p 1075.

[20] Blank RH, *The Price of Life* (Columbia University Press, New York, 1997) p 96.

[21] Hall MA, Bobinski MA and Orientlicher D, *Health Care Law and Ethics* (6th ed, Aspen Publishers, New York, 2003) p 98.

[22] Hall et al, n 21, p 96; Hadorn DC and Brook R, "The Health Care Resource Allocation Debate: Defining Our Terms" (1991) 266 JAMA 3328.

[23] Hall et al, n 21, p 96.

[24] Kilner, n 18, p 1073; Smith AH and Rother J, "Older Americans and the Rationing of Health Care" (1992) 140 U Pa LR 1847.

[25] Childress JF, *Practical Reasoning in Bioethics* (Indiana University Press, Bloomington, 1997) p 96.

[26] Blank, n 20, p 96.

[27] Lamm R, "Rationing of Health Care: Inevitable and Desirable" (1992) 140 U Pa LR 1511; Kilner J, *Who Lives? Who Dies? Ethical Criteria in Patient Selection* (Yale University Press, New Haven, 1990).

[28] Waymack MH, "Old Age and the Rationing of Scarce Health Care Resources" in Jecker N (ed), *Aging and Ethics: Philosophical Problems in Gerontology* (Humana Press, New York, 1991) pp 248, 249.

in providing long-term health protection and happiness for its members as a whole. Sadly, current evidence discloses that this challenge is going unmet.[29]

INTERGENERATIONAL JUSTICE

The concept of intergenerational equity arises from the association between the increased number of persons over 65 years, the probability that they are frequently using health care resources, and the resultant increase in health care costs.[30] The government is not able to bear, without restraint, the growing social and economic health care costs associated with the elderly. In the United States, during the presidency of Ronald Reagan, federal funding failed, for the first time, to keep pace with demand, as the demand for resources far outdistanced the available supply.[31] Every dollar given to programs for the elderly meant one less dollar for other groups. Addressable economic issues included then, as now, the proper delivery of care, the allocation of resources, effective and affordable methods of insurance, and the definition of research priorities.[32]

The fastest growing population in both the United States and world-wide are people over the age of 65.[33] A corresponding shrinkage occurs in the population under 65 years of age who will have to bear the burdens of providing for prior and future generations.[34] Furthermore, the elderly are disproportionate consumers of health care as hospitalisation of elderly persons on the average costs three times more per health care dollar than for those under 65 years of age.[35] Rationing of heath care resources for them is distinguished from cost containment measures which result in a withholding of medical services considered to be of no "expected patient benefit".[36] Thus, age rationing occurs only in those cases "where elderly patients are denied access to medical services that are expected to benefit them".[37]

MEASURING THE QUALITY OF LIFE

A growing, albeit controversial, view in health economics is that the goal of all service should be to create as many years of healthy life as possible for as many people as possible. The underlying basis for this view is, quite simply, the "assumption that for all alike a year of healthy life is equally valuable".[38] The productivity of health care, then, is measured in terms of years of healthy life or quality-adjusted life years (QALYs). Thus, when consideration of the cost of receptive treatments is combined with the length of lives extended and the quality of life they enhance, interesting examples can be posited that force striking conclusions.[39] For example, because hip replacements produce QALYs at approximately one-twentieth the cost of renal hemodialysis, the conclusion is obvious: more replacements should be done. Using the same principle, there should also probably be more

[29] Waymack, n 28, pp 195, 197; Lamm, n 27 at 1511.

[30] Rasinski-Gregory D and Cotler M, "The Elderly and Health Care Reform: Needs, Concerns, Responsibilities and Obligations" (1993) 22 Wes St Univ LR 65 at 83; "Symposium: Intergenerational Equity and Discounting" (2007) 74 Univ Chi LR 5; Smith GP, "Our Hearts Were Once Young and Gay" (1996) 8 Fla JL and Pol'y 1.

[31] Frolik LA and Barnes AP, "An Aging Population: A Challenge to the Law" (1991) 42 Hastings LJ 683 at 708-709.

[32] Callahan D, *Setting Limits: Medical Goals in an Aging Society* (Simon & Schuster, New York, 1987) p 117.

[33] Thomasma DC, "The Ethical Challenge of Providing Healthcare for the Elderly" (1995) 4 Camb Q Healthcare Ethics 144 at 148-149.

[34] Thomasma, n 33 at 148.

[35] Thomasma, n 33 at 148.

[36] Wicclair MR, *Ethics and the Elderly* (Oxford University Press, Oxford, 1993) p 80.

[37] Wicclair, n 36; Smith GP, *Legal and Health Care Ethics for the Elderly* (Taylor & Francis, London, 1996) Ch 4.

[38] Posner RA, *Catastrophe: Risk and Response* (Oxford University Press, Oxford, 2004) pp 165-171.

[39] Hahn R and Wallstein S, "Whose Life is Worth More? And Why Is It Horrible to Ask?", *Washington Post* (1 June 2003) p B3.

coronary bypass surgery for individuals with severe angina and left main vessel disease and more screening and follow-up treatment for mild hypertension because of the qualitative results that follow these procedures.[40]

The aged are disadvantaged significantly by QALYs because quality-adjusted life years measure only treatment endpoints without taking into consideration either the proportional loss or the gain in the quality of one's life. Thus, the major moral criticism of QALYs is that they set no value on life per se.[41]

An alternative to QALYs has been suggested in what is termed "the saved young life equivalent"[42] (SAVE). Although, arguably, still reducing individuals to numbers, this approach seeks a unit of measurement in which saving a young person's life and restoring her or him to full health is the controlling paradigm. This position is justified on the grounds that most people would regard this goal, itself, as the maximum benefit an individual can gain.[43] An assessment of comparative treatment values is thus made "in terms of how many expected outcomes of each treatment would be equivalent to SAVE".[44] Instead of trying to structure a model that seeks to incorporate a defensible method of pricing life and health, QALYs are thought to be a more feasible means of prioritising health care services.

The goal of trying to obtain the most QALYs from a health care system does not force a search for an answer to the central question: what amount of money should be spent per QALY? Thus, quality-adjusted life years will be of considerable use in those contexts in which the question of the amount of resources to spend on health care has presumably been answered; that is, when there is a health budget to stay within, such as in the British National Health Service, an American prepaid plan, or in a rational Medicare plan operating in the 21st century.[45] Indeed, some speculate that soon within this century, QALYs will be accepted totally and used in planning and organising health services.[46]

PROCEDURAL SAFEGUARDS FOR BALANCING NEEDS

In formulating health care policies, the principle of distributive justice demands that decisions such as allocating and rationing health care be made fairly within the political process.[47] Establishing fair procedures for the distribution of health care resources is, then, a crucial goal for contemporary society to set and, hopefully, to achieve. Yet, "most people," it has been said, "are ignorant about most matters."[48] This is true particularly with regard to the health care market where consumers are found to be lacking in basic information about not only the quality but the price of medical services. This ignorance, in turn, means that consumers lack the expertise to evaluate the professional qualifications of health care providers as well as to evaluate necessary information regarding the range of alternative

[40] Menzel PT, *Strong Medicine: The Ethical Rationing of Health* (Oxford University Press, Oxford, 1990) p 80.

[41] Mason JK, Smith RAC and Laurie GT, *Law and Medical Ethics* (Butterworths, London, 2002) p 382; Joish NJ and Oderda GM, "Cost Utility Analysis Quality Adjusted Years" (2005) 19 J Pain and Palliative Care Pharmacotherapy 57.

[42] Mason et al, n 41, p 382.

[43] Mason et al, n 41, p 382.

[44] Mason et al, n 41, p 382.

[45] Anderlik MR, *The Ethics of Managed Care: A Pragmatic Approach* (Indiana University Press, Bloomington, 2001) p 125; Pellegrino ED, "Rationing Health Care: The Ethics of Medical Gatekeeping" (1986) 2 J Contemp Health L and Pol'y 23.

[46] Aaron HJ and Schwartz WB, *The Panel Prescription: Rationing Health Care* (Brookings, Washington, 1984) pp 80, 81; Adler M, "QALYs and Policy Evaluation: A New Perspective" (2006) 6 Yale J Health Pol'y L and Ethics 1.

[47] Smith GP, "Judicial Decision Making in the Age of Biotechnology" (1999) 13 Notre Dame JL Ethics and Pub Pol'y 93; Smith GP, "Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care Protection?" (2005) 39 Vanderbilt J Transnat'l L 1205.

[48] Posner RA, *The Problems of Jurisprudence* (Harvard University Press, Cambridge, Mass, 1990) p 112; Jacoby S, *The Age of American Unreason* (Knopf, New York, 2008).

treatments available to them. Even when price information is available, health care consumers have difficulty assessing and, indeed, comprehending what the data mean and how they impact on access to health care.[49]

Since the efficient use of medical resources dictates that both consumers and health care providers weigh the costs and the benefits of alternative medical treatments, a failure to access health care information regarding these options means, essentially, that physician preferences for particular medical procedures trump the ideal of informed patient consent.[50] And this, in turn, means that the physician solidifies her or his position of power as the primary gatekeeper to health care resources.

A NEED FOR DIALOGUE AND INFORMED DECISION-MAKING

In the final analysis, what is necessary are fair democratic procedures designed to allow average citizens to be informed and knowledgeable in order to make choices among just alternatives for health care resource allocations.[51] Aided by careful cost-effectiveness and cost-benefit analyses, tied, as such, to those discernible values ranked clearly as beneficial and those regarded as costly, such a process could work.[52]

Granted, a public dialogue to reach a *consensus* on how medical resources ought to be distributed is unlikely.[53] Yet a public conversation on these issues of the type the State of Oregon undertook several years ago is available.[54] No matter within what policy forum the health care resource debate occurs – local, state, or national – a fundamental balancing test will, of necessity, be employed: one that weighs, in an equitable and reasonable manner, individual needs with larger societal standards of economic efficiency.[55] By seeking to integrate moral and ethical reasoning with quantitative or economic formulations of needs and resources, the opportunities for a stronger and more contemporary standard of distributive justice will be both enhanced and stabilised.[56]

If agreement could be reached for setting principles of distributive justice which, in turn, would establish a mechanism for determining how to set fair limits to heath care, societies would then be empowered to check all social decisions and practices against the principles in order to determine whether they conformed with them. In cases where decisions, policies and practices failed to conform, they would be held unjust and actions would then be taken to change them. When disagreements arose over the interpretation of principles or facts, legal procedures for resolving such disputes would be sought.[57]

Ideally, the establishment of a national minimum standard of health care, delineating what an adequate level of care should be for managed care organisations, would allow the managers within it and the physicians who are practising under it to take a positive step toward resolving present inadequacies in the system. Once such a standard is in place, there will be some level of expectation that competition will "take place not on establishing the leanest rationing strategy the market will bear (however ethically problematic it may be), but on delivering the agreed minimum standard

[49] Furrow BR, Greaney TL, Johnson SH, Jost T and Schwartz RL, *Bioethics: Health Care Law and Ethics* (Thomson-West, Eagan, 2001) p 478.

[50] Furrow et al, n 49, p 479.

[51] Blank, n 20, p 254.

[52] Blank, n 20, p 254.

[53] Blank, n 20, p 98.

[54] Robinson EL, "The Oregon Basic Health Services Act: A Model for State Reform" (1992) 45 Vanderbilt LR 977.

[55] Anderlik, n 45, p 130.

[56] Pellegrino ED and Thomasma DC, *A Philosophical Basis of Medical Practice: Toward A Philosophy and Ethic of the Healing Professions* (Oxford University Press, Oxford, 1981).

[57] Daniels, n 9, p 14.

efficiently".[58] This standard would demand of the physician an ethical obligation to individual patients "to interpret it in the light of the patient's circumstances and make certain it was offered to them".[59]

Realistically, designing a satisfactory mechanism for defining a morally acceptable threshold standard of care is problematic. Reaching a political consensus on this challenge is even more daunting when the level of public "understanding" and, indeed, lethargy is appreciated, if not accepted.[60] Consequently, for the foreseeable future, health care policy-making will remain mired in perplexities and uncertainties and, thus, unresponsive to the ideal of achieving a level of distributive justice in allocating health care resources.

[58] Bailey MA, "Managed Care Organizations and the Rationing Problem" (2003) 33 *Hastings Center Report* 34 at 40; Pellegrino, n 45 at 23.

[59] Bailey, n 58, p 40; Hirshfeld EB, "Should Ethical and Legal Standards for Physicians be Changed to Accommodate New Models of Rationing Health Care?" (1992) 140 U Pa LR 1809.

[60] Posner, n 48, p 112.